



Maine Department of Health and Human Services

MECMS Update 53

March 6, 2006

Billing News & Tips

Careful billing can reduce suspended and denied claims...

In past issues of *MeCMS Update*, we've shared that little things can result in the denial or suspension of your claims. The Office of MaineCare Services (OMS) recently analyzed the top reasons for suspended and denied claims. This analysis showed several things that you can do to reduce the potential that your claims will be delayed or denied.

Here are some helpful hints to remember when submitting bills.

Tips for paper claims...

OMS uses scanning technology to convert hard-copy claims into electronic data for processing. If you submit hard-copy claims, **make sure that data appears clearly within the appropriate boxes on the CMS-1500 or UB-92 claim form.**

Our system will read any data that bleeds into an adjoining field as data for that field. Here are two recent examples that caused claims to suspend:

- For UB-92 claims, some providers are entering a narrative description that extends outside of Box 43 of the form. When this happens, claims suspend for an invalid procedure code in Box 44.
- For CMS-1500 claims, some providers are not clearly entering a "Y" in Box 24I: EMG

or Box 24J: COB. Use of these fields means different things for claims processing. When the data is not clearly in one field or the other, claims may suspend or deny in error.

Accurate member information is critical...

Please make sure that the member's ID number, name, gender, and date of birth are correct in all required fields of the claim form. Here are some tips:

- Submit the patient's name as indicated on his/her MaineCare ID card.
- Make sure to correctly key member numbers and dates of birth.
- Do not leave the member number field blank.
- Use the patient's MaineCare member number—not a Social Security Number (SSN)—when submitting claims.
- Be sure to bill claims for newborns under the newborn's name, date of birth, and member number.

Know your patient's benefits...

Some MaineCare members are only eligible to receive limited benefits. You should always verify a member's eligibility prior to providing services. If the member has a limited benefit, please contact OMS at 1-800-321-5557, Option 9, to verify that the service to be provided is a covered service for the member.

Billing provider ID numbers must be accurate...

The OMS study of suspended claims also reflects the importance of correctly using Billing Provider ID numbers. MaineCare Billing Provider ID numbers are **nine-digit numbers**.

Some **common billing errors** include:

- Keying Billing Provider IDs incorrectly.
- Submitting Billing Provider IDs that have more than nine digits.
- Submitting Servicing Provider IDs (those ending in “99”) instead of Billing Provider IDs.
- Submitting alphanumeric numbers for Billing Provider IDs (such as numbers beginning with “ME”).

Some billing errors relate specifically to CMS-1500 claims. **When billing on a CMS-1500 claim form:**

- Enter your nine-digit Billing Provider ID number in Box 33-PIN#. Do not enter a Servicing Provider ID in that field. If the services billed require a Servicing Provider ID, you should enter that number in Box 24K.
- Do not enter your Billing Provider ID in Box 33-GRP#.

Use of up-to-date procedure coding speeds processing...

The use of outdated procedure codes is a common reason for suspended and denied claims. When billing, please make sure to use up-to-date procedure codes.

A special note for dentists... If you are a dental care provider, please make sure you are using procedure codes beginning with a “D” as required by HIPAA. If you submit dental procedure codes beginning with “0”, claims cannot be processed and will be denied.

Modifiers matter...

Another common reason for suspended and denied claims is improper use of modifiers. Here are a few tips:

- Modifier “51” designates multiple procedures that are rendered at the same operative session or on the same day. A common provider billing error is failing to include the “51” modifier when it is required. Appendix E of *CPT 2006* includes a list of the procedures that **are exempt** from the use of modifier 51 but **have not** been designated as CPT add-on procedures/services. Please carefully consider these requirements when billing.
- Modifier “78” is used to report related procedures performed in the operating room within the assigned postoperative period of a surgical procedure. Please note that you need to provide OMS with a written report of the procedure performed when billing this modifier.

Billing after Medicare requires special attention...

The OMS study of suspended claims showed many billing errors related to claims billed after Medicare.

Please refer to the billing instructions on the MaineCare website at <http://www.maine.gov/dhhs/bms> for detailed instructions on how to properly bill after Medicare. Incorrect billing may result in claim denials.

Minimizing suspect duplicate claims...

Some provider billing practices increase the potential that claims will suspend as suspect duplicates. For example:

- If you submit claims with dates of service that cover a weekly time period, and then
- Submit claims with dates of service that span the entire month (including the initially submitted weekly claims), then
- Claims will suspend as potential duplicates, which requires manual review of the claims.

To minimize the potential of this happening, please do not submit both weekly and monthly bills for the same member and dates of service.

Issues with prior authorizations are the top reason claims suspend...

Many claims suspend or deny for issues related to prior authorizations. **Common billing errors** include:

- Keying prior authorization numbers incorrectly.
- Entering referral numbers in Box 23 of the CMS-1500 form instead of nine-digit prior authorization numbers.
- Handwriting prior authorization numbers on the face of the claim instead of in the designated box.
- Submitting procedure codes that do not match the authorized services.

Some additional notes...

- If you are an out-of-state provider, please do not key prior authorization numbers in referral fields.

- If you provide circumcision services, please note that this procedure **always** requires prior authorization by OMS.

All providers except Social Service providers can verify prior authorization numbers at the OMS Prior Authorization Portal at:
<http://portalxw.bisoex.state.me.us/oms>

If you are a Social Service provider, please contact the local office where your authorization was issued to verify a prior authorization number.



We appreciate your attention to the billing tips presented in this update! Close attention to these tips will allow us to serve you better.



Contact Us

E-mail us at: BMS.inquiry@maine.gov

Call us at: 1-800-321-5557
TTY: 1-800-423-4331
Augusta area: 207-624-7539

On the web at: www.maine.gov/dhhs/bms

Write us at: Inquiry Unit
Office of MaineCare Services
11 State House Station
Augusta, ME 04333-0011

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